Section 11

Medical Policies and Prior Authorization

Contents

Medical Policies – Overview

For most commercial plans, Blue Cross® Blue Shield® of Arizona (AZ Blue) uses many nationally recognized medical policy guidelines. This includes best-in-class, evidence-based criteria developed by eviCore, MCG Health ("MCG"), American Specialty Health (ASH), and the National Comprehensive Cancer Network® (NCCN®). We also use policies developed by the BCBS Association in developing our own proprietary evidence-based criteria, based on emerging science and technology, medical literature, and credible clinical data.

Note: Although we started using MCG care guidelines on November 1, 2023 (replacing our use of the InterQual® guidelines), we will refer to InterQual for applicable guidelines in effect prior to November 1, 2023.

Medical policies used for Medicare Advantage plans administered by AZ Blue
The primary criteria used for Medicare Advantage plans are the CMS National Coverage Determinations (NCD) and the Local Coverage Determinations (LCD). If there are no applicable NCD or LCD criteria and the service is included in our eviCore program for MA (high-tech radiology, oncology, radiation therapy, lab management, spine/joint surgery, and interventional pain management), eviCore will apply other nationally recognized guidelines or its own guidelines as appropriate. If not addressed by NCD, LCD, or eviCore, we may use AZ Blue proprietary policies or MCG® care guidelines to determine medical necessity. We use ASH guidelines for chiropractic services.

For inpatient review (acute and post-acute settings), we use MCG® care guidelines to determine medical necessity.

We follow the same hierarchy of sources for Part B drug guidelines. When there is no applicable guideline from those sources, we reference Micromedex® to see if the drug is FDA-approved for the patient's indication. We use the OptumRx Part D prior authorization guidelines.

FEP medical policies
Clinical criteria applicable to FEP members is based on the FEP medical policies and utilization management guidelines listed on the FEP website. MCG is used for inpatient review (acute and post-acute settings).

Medical policies used by other plan administrators
Please note the following plans that may use other medical and administrative policies that might differ from ours, including determination of what services are considered experimental and investigational:

- Plans for some self-funded employer groups may be administered by a third-party administrator.
- Our ACA StandardHealth with Health Choice plan (prefix IAZ) – medical determination criteria is available at https://standardhealthhc.com./providers/clinical-guidelines.
- Some of our Medicare Advantage HMO plans are administered by OptumCare Arizona (as indicated on the back of the ID card).
- Plans from other BCBS payers may use other utilization management guidelines.

AZ Blue review of clinical criteria
We review most clinical criteria applicable to AZ Blue-administered plans at least annually, and more often as new material data becomes available. Medical and scientific resources for these criteria include, but are not limited to:

- High-grade, published, peer-reviewed, medical, and scientific literature

Medical Policies – Overview

- Expert specialty reviews
- Professional medical organizations' position statements to support determinations concerning such matters as medical necessity, procedural coverage, and benefit determination and development

Credible criteria must meet the following requirements:

- The technology must have final approval from the appropriate governmental regulatory bodies.
- The scientific evidence must permit conclusions concerning the technology's effect on health outcomes.
- The technology must improve the patient's net health outcome.
- The technology must be as beneficial as any established alternative.
- The improvement must be attainable outside of the investigational setting.

Impact of changes in medical technology on claim coding and processing
Rapid changes in the practice of medicine and use of associated supporting technologies can sometimes impact claim adjudication. A procedure or diagnostic test may be considered eligible for coverage when applied in one way or to a particular diagnosis, and not considered eligible for coverage when applied in a new way or for a different diagnosis because recognition of its efficacy in these new circumstances is still developing.

An existing CPT or HCPCS code may not accurately describe the combination of a procedure or diagnostic test and the corresponding utilization. Consequently, AZ Blue may inadvertently pay a claim that properly should have been denied as non-covered or excluded, and vice versa.

When AZ Blue receives information about a technology that is being considered for use in a new way, we assess that application for medical safety and efficacy. This assessment may result in a clarification to our clinical criteria. If so, that can result in denials of new claims for procedures that were previously paid or payment of new claims for procedures that were previously denied.

Medical Policy Access – Quick Guide

TYPE OF PLAN	HOW TO ACCESS MEDICAL POLICIES
AZ Blue Commercial Plans	Access the following resources in the AZ Blue provider portal at "Practice Management > Medical Policies" • eviCore guidelines • AZ Blue proprietary policies • MCG care guidelines • Site-of-Service Requirements (for certain medications) • ASH chiropractic guidelines • Pharmacy coverage guidelines (for drugs covered under pharmacy benefits) If you can't find policies by accessing the above resources, call 602-864-4614
ACA StandardHealth with Health Choice Plan	**Prefix IAZ:** Visit https://standardhealthhc.com./providers/clinical-guidelines or call 1-800-322-8670
Federal Employee Program® (FEP®) Plans	fepblue.org/legal/policies-guidelines
BlueCard® (Out-of-Area) Plans	Use the BlueCard medical policy router tool in the AZ Blue provider portal at "Practice Management > Medical Policies" to access medical policy resources for the member's home plan
Corporate Health Services (CHS) Group Plans (administered by TPAs)	Check the back of the member ID card for utilization management information
AZ Blue-TPA Co-Administered Plans	**Prefixes K8Y and K8Z** (Amkor Technology, Inc.; Group # 039176): Contact AmeriBen at 1-800-388-3193 **Prefix NBT** (NAEBT; Group # 037461): Contact American Health Group at 1-800-847-7605 **Prefix PTP** (Pioneer Title Holding Company, Inc.; Group # 044410): Contact AmeriBen at 1-800-388-3193
Medicare Advantage (MA) Plans administered by AZ Blue	• CMS National Coverage Determinations (NCD) • Local Coverage Determinations (LCD) • eviCore guidelines • AZ Blue proprietary policies • MCG care guidelines – Call AZ Blue at 1-800-446-8331
MA HMO Plans administered by Optum (as indicated on the back of the ID card)	https://providers.optumcaremw.com

Prior Authorization – Overview

Prior authorization is not a guarantee of payment

Prior authorization is the process AZ Blue uses to determine a member's eligibility for a requested procedure or service before the service is rendered. Authorization decisions are based on the member's eligibility, condition, specific benefit plan, and any related evidence-based clinical criteria and pharmacy coverage guidelines.

Regardless of prior authorization decisions, patient care decisions are made between the provider and patient. The fact that a provider has prescribed, ordered, recommended, or approved a service or supply does not make it medically necessary or make the service eligible for benefits, even though it is not expressly excluded in the member's benefit book.

Prior authorization requirements

Prior authorization is required for all scheduled inpatient admissions and certain outpatient procedures, services, items, and medications. Our standard prior authorization requirements apply to most AZ Blue commercial benefit plans. Some plans use other requirements, including:

- Certain large, self-funded groups have customized prior authorization requirements.
- Requirements for our ACA StandardHealth with Health Choice plan (prefix IAZ) are available at https://standardhealthhc.com/providers/pa-guidelines.
- CHS group plans use a third-party administrator (TPA) and have their own utilization management arrangements (see page 11-9).
- BlueCard (out-of-area) plans are governed by the member's BCBS Plan (see page 11-8).
- FEP plans are governed by the Office of Personnel Management (see page 11-11).
- AZ Blue Medicare Advantage (MA) plans have different prior authorization requirements (see page 11-13).
- Medicare Supplement plans (designed to cover payment gaps for those with traditional Medicare plans) align with CMS for coverage and medical necessity determinations. However, if a member's Medicare Supplement plan covers benefits for foreign travel emergency services, AZ Blue will determine medical necessity.

How to access prior authorization requirements

For provider reference, we post prior authorization requirements on our prior authorization and medical policies page. Select the member's plan type to access the applicable prior authorization code list and lookup tool.

Prior authorization process

Prior authorization must be requested *before* the service is rendered. See page 11-19 for information about how to request prior authorization. The review typically considers:

- Member eligibility and benefit coverage, including contract limitations, exclusions, waiting periods, waivers, or benefit maximums that apply to the requested service or procedure
- Provider network status and any site-of-service requirements
- Medical necessity of procedures or treatments based on applicable clinical standards and criteria (see page 11-1)
- The use of procedures or items that might be considered experimental or investigational

Prior Authorization – Overview

Note: Even if a service has been authorized and rendered, all benefit plan provisions (e.g., eligibility, waiting periods, limitations, exclusions, waivers, and benefit maximums) still apply, even if they weren't readily determinable at the time prior authorization is given.

eviCore program

For the services and plans listed below, eviCore handles prior authorization on our behalf.

EVICORE SOLUTION	APPLICABLE AZ BLUE PLANS
Lab Management – Genetic testing	Most commercial plans for employer groups and individuals under age 65 and their families, and *AZ Blue-administered* Medicare Advantage (MA) plans
Medical Oncology – Infused drugs (may include site-of-service requirements); supportive agents; companion diagnostics	
Radiation Oncology – Radiation treatment (clinical and non-clinical modalities)	
Radiology – High-tech imaging	
Specialty Drug Management – Drugs that must be administered by a healthcare professional and are covered only under medical benefits	Only for commercial group and individual/family plans (not for MA plans)
Musculoskeletal – Spine and joint surgery and interventional pain management services	*AZ Blue-administered* MA plans only

eviCore prior authorization does **not** apply to FEP or CHS group members, or BlueCard (out-of-area) members from other BCBS Plans. Also, certain large self-funded AZ Blue-administered groups may opt out of the eviCore utilization management program.

To check if a commercial group member is delegated for eviCore, check eligibility and benefits using service type 30: Health Benefit Plan Coverage. The message says: eviCore delegated member for high-tech imaging, genetic tests, oncology, radiation therapy, specialty meds.

To request prior authorization from eviCore, please use their online request tool. *Note: Although this tool is different from the Arizona standardized request forms,* ***AZ Blue will accept prior authorization requests submitted through eviCore's online tool as valid.***

For program information, code lists, and clinical guidelines, visit our eviCore provider resource page.

Gold Card Prior Authorization Program

Our Gold Card Prior Authorization Program offers qualifying network providers quick and easy authorization approval for services they render to members with AZ Blue commercial benefit plans. The Gold Card designation recognizes providers with an excellent track record for adhering to evidence-based clinical criteria and a recent history of very few or no prior authorization request denials. This merit-based approval privilege does not extend to facilities or to any provider who has not been invited by AZ Blue to participate in the Program.

Applicable services: Gold Card prior authorization approvals apply only to services covered by medical benefits that are personally rendered to a patient by a Program provider. The Gold Card privilege also applies to services ordered by a Program provider (such as high-tech imaging or genetic testing) when the Program provider requests/obtains the prior authorization.

Services excluded from the Program include certain codes indicated on the prior authorization requirements list, medications (covered under both medical and pharmacy benefits), medical devices, DME, clinical trials, transplant services, and out-of-network services.

For more information about the program, visit azblue.com/goldcard.

Prior Authorization – Overview

Inpatient care notification and/ prior authorization requirements
All of our benefit plans require notice of inpatient admissions. Some plans also require prior authorization for all scheduled inpatient admissions and continued stays. For plan-specific information and time frames, check eligibility and benefits, and refer to the Inpatient Notification and Prior Authorization Requirements-Quick Guide on page 11-20.

For information about how to notify us or request authorization, see page 11-19.

Inpatient transfers to different levels of care
If a member is transferred from acute care to post-acute care or from acute care to another acute care facility for the same or lower level of care, prior authorization is required. For details, see the Inpatient Notification and Prior Authorization Requirements-Quick Guide on page 11-20.

How to request prior authorization or notify us of inpatient admissions
Most notifications and prior authorization requests can be made online – see specific information on page 11-19.

We require the following information to process a notification or prior authorization request:

- Member/subscriber name, date of birth, and ID number
- Provider name(s), NPI, specialty, and contact information
- Date, type, and place of service
- Applicable procedure(s) and procedure code(s)
- Applicable diagnoses and diagnosis code(s)
- Other relevant information specific to the request

Penalties
For most AZ Blue and BlueCard (out-of-area) commercial benefit plans, AZ Blue will assess a $500.00 penalty to the servicing network provider for failure to obtain prior authorization for services requiring prior authorization under the member's benefit plan. For facility-related prior authorization requirements (such as inpatient admissions, SNF, EAR, and LTAC), the penalty applies to the facility and not the professional provider. Providers considered in-network for the member's benefit plan may not bill the member for this penalty amount.

Exception: For members with commercial PPO plans, a penalty may be applied to the member when the rendering provider is out-of-network and a required prior authorization was not obtained.

To avoid unnecessary penalties, ensure all required prior authorization is obtained *before* servicing the member. If you have received prior authorization, include the identifier on your claim submission.

Out-of-network referrals require prior authorization
AZ Blue network providers must refer members only to contracted providers considered in-network for the member's benefit plan. When non-emergency covered services are not reasonably available within the member's specific network, prior authorization is required for use of an out-of-network provider. The referring provider must also advise the member of non-network status (except in emergency situations).

If AZ Blue authorizes an exception:

- **Members with HMO plans** are covered for the authorized out-of-network service and held harmless against any balance billing.

Prior Authorization – Overview

- **Members with PPO plans** have an out-of-network benefit with higher out-of-pocket costs. The approved prior authorization will give the member the in-network coinsurance and deductible. The member is still responsible for any balance bill, unless within scope for the balance billing protections in the No Surprises Act (NSA).
- **Members with FEP plans** have plan provisions for situations in which the member has little, or no, choice in selecting a provider. Benefits cover certain types of services at preferred (in-network) levels when provided by non-participating professionals. Examples include non-participating providers, such as hospital-based providers, when the care is provided at a preferred facility other than the emergency room. FEP members are also covered under the NSA balance billing protections.

Prior authorization requirements for medications

For medications covered under the **retail/mail-order pharmacy benefit:**

- For commercial plans, you can access detailed information at azblue.com/Pharmacy.
- Some self-funded employer groups with customized benefit plans may use other (non-AZ Blue) pharmacy benefit administrators or carriers for pharmacy benefits. Be sure to check eligibility and benefits for each member.
- For FEP plans, see the online list of medications requiring prior approval and other information on the pharmacy FAQs page.
- For MA plans, see the AZ Blue MA formulary (prescription drug list).

For medications covered under **medical benefits**:

- For commercial plans, prior authorization requirements are included in the AZ Blue prior authorization code lists, available in the azblue.com secure provider portal at “Practice Management > Prior Authorization.”
- For FEP plans, see the online list of medications requiring prior approval and get more information at fepblue.org/prior-approval.
- For MA plans, Part B drugs that require prior authorization are included in the AZ Blue MA prior authorization code list on our prior authorization and medical policies page.

AZ Blue and TPA Co-Administered Plans

Large self-funded groups may opt to have their PPO health plan co-administered by AZ Blue and a third-party administrator (TPA). When this is the case, the member ID card will display a disclaimer in the lower left corner of the front of the card stating that the employer group uses a TPA to handle member contact for health plan administration.

Utilization management for these plans is handled by the TPA – see below for details.

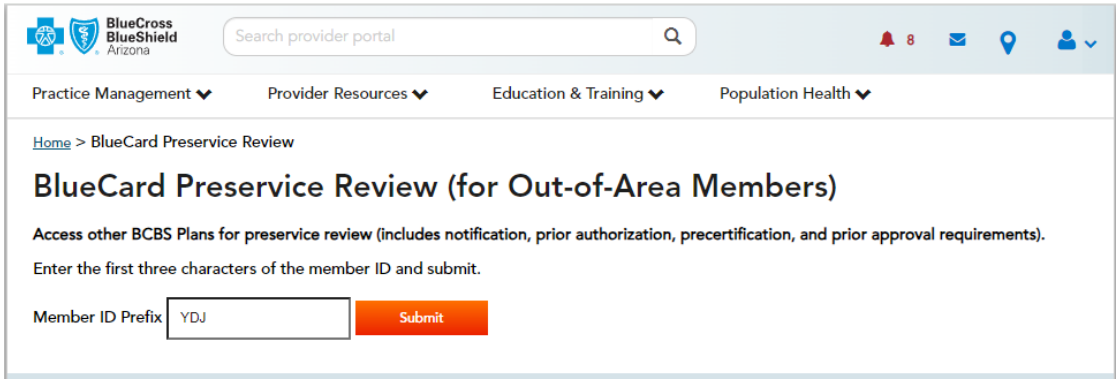
Employer Group	Prefix	Third-Party Administrator
Amkor Technology, Inc. Group # 039176	**K8Y** **K8Z**	Utilization Management: AmeriBen **1-800-388-3193** PBM: Navitus **1-866-333-2757**
Northwest Arizona Employee Benefit Trust (NAEBT) Group # 037461	**NBT**	Utilization Management: Health Group (AHG) **1-800-847-7605** PBM: Navitus **1-866-333-2757**
Pioneer Title Holding Company, Inc. Group # 044410	**PTP**	Utilization Management: AmeriBen **1-800-388-3193** PBM: Magellan **1-800-424-0472** (magellanrx.com)

BlueCard (Out-of-Area) Plans

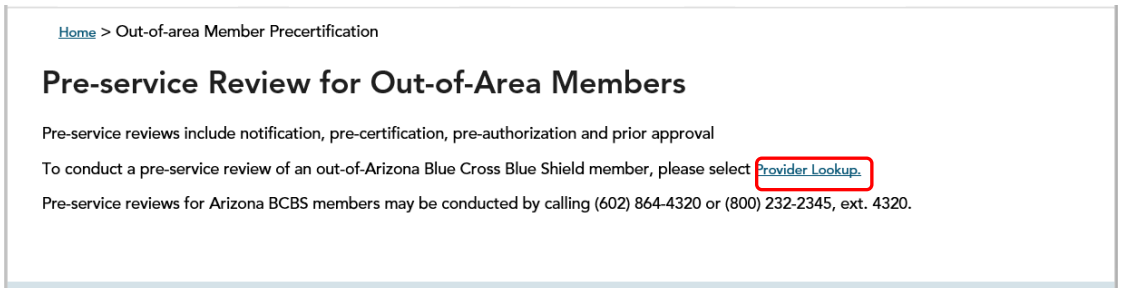
Preservice review for BlueCard (out-of-area) members

Preservice review includes notification, precertification, prior authorization, and prior approval. The online tool for out-of-area member pre-service review allows providers to access other BCBS Plans' websites and use available online resources. It uses a secure routing mechanism initiated by entering the member ID prefix. Using the tool is simple:

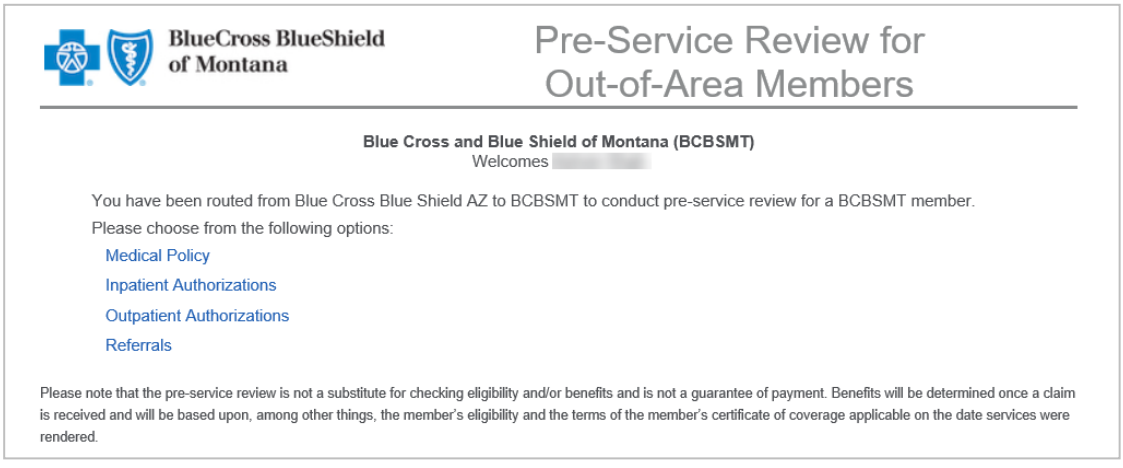
1. Log in to the AZ Blue provider portal and go to "Practice Management > Prior Authorization > BlueCard (Out-of-Area) Members."
2. Enter the member ID prefix (first three characters) from the member's ID card.



3. On the next screen, click on the "Provider Lookup" link to validate your provider NPI. After validation, the tool will securely route you to the member's BCBS Plan's landing page.



4. Sample of a pre-service review landing page.



Because processes for pre-service reviews vary from one BCBS Plan to another, landing pages may include information about online pre-service reviews, a phone number, or other instructions.

Corporate Health Services (CHS) Group Plans

Prior authorization requirements for a Corporate Health Services (CHS) group member can be accessed by contacting the group's prior authorization administrator. The contact information is included in the CHS/TPA information list and search tool results, available in the AZ Blue provider portal. Go to "Practice Management > Eligibility and Benefits > CHS Group Information."

Most CHS group member ID cards also display a prior authorization contact number on the back. If you have questions, contact the group's TPA.

Reminder: **Prior authorization is not a guarantee of payment.** Prior authorization is the process used to determine a member's eligibility for a requested procedure or service before the service is rendered. Authorization decisions are based on the member's eligibility, condition, specific benefit plan, and any related evidence-based clinical criteria and pharmacy coverage guidelines.

Federal Employee Program (FEP) Plans

Federal Employee Program (FEP) precertification and prior approval

FEP uses two processes for pre-service reviews:

- **Precertification** is the process by which, prior to an inpatient admission, AZ Blue evaluates the medical necessity of the proposed stay, the procedure or service to be performed, the number of days required to treat the member's condition, and any applicable benefit criteria.
- **Prior approval** is written assurance that benefits will be provided by the BCBS Plan where the services will be performed, or by the retail pharmacy program, the mail service prescription drug program, or the specialty drug pharmacy program. Prior approval is required for certain services.

Some services require both precertification and prior approval.

Precertification and prior approval requirements

You can find FEP precertification and prior approval requirements in our compiled code lists Excel file. You'll find it in the AZ Blue provider portal at "Practice Management > Prior Authorization > AZ Blue Members-Prior Auth Code Lists."

All requirements are explained in more detail in the FEP health plan brochures at fepblue.org/plan-brochures. You can also visit the FEP medical policy page for information about clinical criteria.

Requesting FEP precertification and prior approval

The attending physician, provider, or facility must request precertification or prior approval before all inpatient admissions or the rendering of other services requiring precertification or prior approval. To request, call the AZ Blue FEP team at 602-864-4102 or 1-800-345-7562.

- If the member has an **emergency admission**, you must notify us and obtain authorization for a continued stay within two business days following the day of the emergency admission. If the member has been discharged from the hospital, you must still notify us.
- FEP requires the following information for inpatient admission precertification:
  - Enrollee's name and plan ID number
  - Patient's name, birth date, and phone number
  - Reason for inpatient admission, proposed treatment, or surgery
  - Name and phone number of admitting physician
  - Name of hospital or facility
  - Number of days requested for inpatient stay
  - If the admission is to a residential treatment center (RTC), include a preliminary treatment and discharge plan that has been agreed on by the member, admitting provider, AZ Blue case manager, and the RTC
  - Other information as requested

We will inform the provider of the number of approved inpatient days and send written confirmation of the decision to the member, physician, and hospital.

Predetermination requests

FEP issues predeterminations (also known as advance benefit determinations) for services that are likely to cost more than $7,000.00. This preview offers providers a preliminary review of the medical necessity determination for the service. It is *not* a prior authorization. To request a predetermination, call the AZ Blue FEP team at 602-864-4102 or 1-800-345-7562.

Federal Employee Program (FEP) Plans

Penalties for failure to obtain required precertification and prior approval
Current precertification and prior approval requirements for FEP members are available via our Prior Authorization and Medical Policies page or the AZ Blue provider portal at Practice Management > Prior Authorization > AZ Blue Members-Prior Auth Code Lists."

1. Penalties (for all FEP benefit plans)
   AZ Blue will assess a $500.00 penalty to the servicing network provider for failure to obtain precertification for all services requiring precertification for FEP members. For facility-related precertification requirements (such as inpatient admissions, SNF, EAR, LTAC, and RTC), the penalty applies to the facility and not the professional provider. This penalty may not be billed to the member.
2. Prior approval penalties (only for FEP Blue Focus benefit plans)
   AZ Blue will assess a $100.00 penalty to the servicing provider *and* the facility for failure to obtain prior approval for all services requiring prior approval for FEP Blue Focus members.

Medicare Advantage (MA) Plans

Utilization management for Medicare Advantage members

1. **AZ Blue:** We administer prior authorization for all BlueJourney PPO plans and some of the Blue Best Life HMO plans. On the back of the ID card you'll see the AZ Blue claim filing information and prior authorization phone number.

   Note: The plans we administer include an eviCore utilization management program for medical oncology, radiation therapy, high-tech radiology, genetic testing, spine/joint surgeries, and interventional pain management services.

2. **OptumCare Arizona:** We partner with OptumCare Arizona for utilization management (and claim/payment) services for a subset of our Blue Best Life HMO membership in Maricopa and Pinal counties. These members can be identified by the Optum claim filing information and prior authorization phone number on the back of the ID card.

Prior authorization requirements

For AZ Blue prior authorization requirements, visit our Prior Authorization and Medical Policies page. For the OptumCare Arizona code list, visit the Optum Prior Authorization List page.

How to request prior authorization

Check the back of the member ID card for the plan administrator. Submit prior authorization requests as indicated in the table below.

BENEFIT PLAN NAME	PREFIX	SERVICE AREA	PRIOR AUTHORIZATION REQUESTS
Blue Best Life Classic and Plus HMO plans administered by AZ Blue (as indicated on the back of the ID card)	**M2K**	Maricopa, Pinal, and Pima counties	**AZ Blue and eviCore** (for certain services) **eviCore ONLINE:** Log in to eviCore.com/provider **AZ Blue FAX FORM** (prior authorization and medical policy page): Standard: 602-544-5652 / Expedited: 602-544-5651 Inpatient Notification: 602-544-5653 Concurrent Review: 602-544-5654 Post-acute Care/Behavioral Health: 602-544-5654 Part B Drugs: 602-544-5622 Part D Drugs: 1-844-883-8523 (retail); 1-800-791-7658 (mail-order) Online: covermymeds.com/main/prior-authorization-forms/optumrx **PHONE** (after hours immediate service): 1-800-446-8331
BlueJourney PPO plans	**M3P**	Maricopa and Pima counties	
Blue Best Life Classic and Plus HMO plans administered by Optum (as indicated on the back of the ID card)	**M2K**	Maricopa and Pinal Counties	**OptumCare Arizona** **ONLINE:** https://providers.optumcaremw.com **FAX:** 1-888-992-2809 **PHONE:** 1-877-370-2845

Inpatient notification and prior authorization requirements

All of our MA benefit plans require notification and/or prior authorization for inpatient admissions. Notification of unscheduled admissions is required within 24 hours of admission or by the next business day.

NOTIFICATION OF UNSCHEDULED ADMISSIONS	
AZ Blue	**OptumCare Arizona**
Fax: 602-544-5653	Fax: 1-888-992-2809
Phone: 1-800-446-8331	Phone: 1-877-370-2845

Medicare Advantage (MA) Plans

Coverage determination criteria for unscheduled admissions follows MCG care guidelines and includes:

- Severity of signs/symptoms
- Medical predictability of an adverse event
- Need for care that can only be delivered safely and effectively in the inpatient setting

Prior authorization requirements for medications

- Part B drugs that require prior authorization are included in the AZ Blue Medicare Advantage prior authorization code list. Many of these drugs also require step therapy. You can find the code list and step therapy policy on our prior authorization and medical policies page.
- For Part D drugs, you can access the AZ Blue MA formulary (prescription drug list) to see if a particular drug requires prior authorization or step therapy, or has quantity limits." OptumRx phone numbers and request options**:**

Retail Pharmacy Benefits	Phone: 1-844-883-8523	ePA: covermymeds or surescripts
Mail Order Pharmacy Benefits	Phone: 1-800-791-7658	Fax: 1-800-491-7997 | ePA: covermymeds or surescripts

For more information about pharmacy benefits, see Section 24.

Initial organization determinations

Organization determinations are decisions made by AZ Blue (or other utilization management administrator) about MA benefit coverage for requested services. MA members, their representatives, and providers may request an initial organization determination when considering services that are not typically covered by Medicare or by the member's MA benefit plan. All services must meet medical necessity criteria.

To request an initial organization determination on behalf of a member, download and submit the MA prior authorization request fax form, located on our prior authorization and medical policies page.

Additional MA prior authorization resources

You can find AZ Blue prior authorization resources on our prior authorization and medical policies page and in the MA provider portal at azbluemedicare.com/login in the "Prior Authorizations" and "Resources" sections. The portal also includes a prior authorization status tool.

You can also visit our eviCore resource page for clinical guidelines and code lists.

Peer-to-Peer Requests – AZ Blue

AZ Blue peer-to-peer conversations (for eviCore peer-to-peer consultations, see page 11-18)
An AZ Blue peer-to-peer conversation is a one-on-one discussion between an AZ Blue medical director or clinical advisor and a treating physician, nurse practitioner, or physician assistant. These phone conversations are intended to help you understand how we determine if medical necessity criteria have been fully met.

There are some important differences between AZ Blue and eviCore peer-to-peer processes and also in how peer-to-peer consultations may be used for Medicare Advantage (MA) plans, in keeping with CMS guidance. Here are the guidelines:

- **For our commercial plans,** an AZ Blue peer-to-peer conversation is about an adverse medical necessity decision on a prior authorization request that was submitted ***before*** the service was rendered. You must request the peer-to-peer conversation within seven calendar days of the date on the prior authorization denial letter and ***before*** initiating the member appeal process.
- **For our MA plans,** an AZ Blue peer-to-peer conversation must be requested ***before*** the prior authorization decision has been made and is typically requested when a prior authorization request has been pended for additional information. To challenge an MA authorization denial, you must submit an appeal.
- **An eviCore peer-to-peer conversation** may be requested at any point in the prior authorization and claim processes. However, the information shared in the consultation can't always be used to overturn the authorization or claim denial.
  - For MA plans, an eviCore consultation may *not* be used to overturn an authorization denial, but the information shared in the consultation may be used in submitting an appeal.
  - For all plans, an eviCore consultation may not be used to overturn an authorization denial ***after*** the service has been rendered.
  - For all plans, an eviCore consultation may *not* be used to overturn a *final* authorization denial decision, but the information shared in the consultation may be used in submitting an appeal.

How to prepare for an AZ Blue peer-to-peer conversation

AZ Blue peer-to-peer conversations focus on medical necessity. The following steps will help you determine if a peer-to-peer conversation is appropriate and how to prepare:

1. Access the clinical criteria for the service or procedure (see page 11-1).
2. Review the clinical criteria to check for applicable indications for the patient's condition or illness.
3. Check to see if the criteria for the applicable indications have been met or mostly met.
4. Check to see if the submitted medical records document that criteria are met.

Situations that are not eligible for an AZ Blue peer-to-peer conversation

Below are some common situations and topics that do *not* qualify for a peer-to-peer conversation:

- Benefit plan exclusions and non-covered benefits; examples of this would be dosing outside the FDA-recommended doses, out-of-network services, and services and items considered experimental or investigational
- Retrospective reviews where prior authorization was required but not obtained prior to the services being rendered

Peer-to-Peer Requests – AZ Blue

- Denied claims—for any reason
- Active, denied, or upheld member appeals—for claims or prior authorization
- Decision about credentialing or waivered conditions
- AZ Blue clinical criteria
- Requests received after seven calendar days from the prior auth denial letter receipt date

How to request an AZ Blue peer-to-peer conversation
For AZ Blue and Federal Employee Program (FEP) members, call and leave a voicemail message on the peer-to-peer phone line at 602-864-4209 or 1-800-232-2345, ext. 4209. We will return your call within one business day.

- For Medicare Advantage members, call the reviewer's phone number (included in the denial letter).
- For BlueCard (out-of-area) members, call the member's BCBS Plan.
- For Corporate Health Services (CHS) group members, call the group's TPA at the number displayed on the member ID card.
- For eviCore peer-to-peer conversations, follow the instructions in the prior authorization denial notice.
- For Pharmacy-related requests, call 602-864-4028.

Member appeals
A member appeal/reconsideration process is available if a prior authorization request for a service or procedure is not approved. Refer to Section 23 for a summary of the member appeal processes, including an expedited appeal process for urgently needed services not yet provided.

Peer-to-Peer Requests – eviCore

You may request an **eviCore** clinical consultation at any time during the prior authorization and claim processes. How the consultation may be used varies depending on if the request is for a Medicare Advantage (MA) member and if a determination (decision) has been made:

- If your MA prior authorization request has been pended for additional clinical information, follow the instruction on the notice from eviCore. If the determination has not yet been made, the consultation could influence the initial decision.
- If an MA prior authorization denial decision has already been made, the information shared in an eviCore consultation may *not* be used to overturn the denial. However, the information may be used in submitting an appeal.

eviCore authorization scenarios and follow-up options

See below for different situations and the options available for commercial and MA plans.

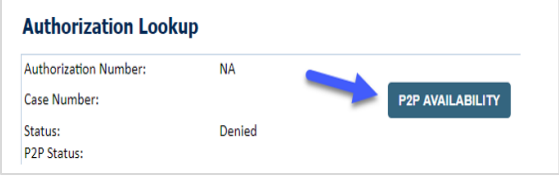
SCENARIO	COMMERCIAL PLANS	MEDICARE ADVANTAGE PLANS
1. My authorization request was pended for additional information. ***I haven't rendered the service yet.***	Request eviCore peer-to-peer clinical consultation or submit additional clinical information to eviCore.*	
2. My authorization request was denied. ***I haven't rendered the service yet.***	Request eviCore reconsideration (re-review) within 7 calendar days of the denial for potential overturn of denial.*	Request eviCore consultation or submit appeal with supporting records to AZ Blue.* eviCore consultation can't be used to overturn the denial. You must file an appeal.
3. My authorization request was denied. ***I have already rendered the service but haven't submitted a claim yet.***	Submit appeal with supporting records to AZ Blue.*	Submit claim with supporting records to AZ Blue.
	eviCore consultation can't be used to overturn the denial.	
4.* Oops! I didn't request authorization** ***before rendering the service. ***I haven't submitted a claim yet.***	Request post-service retrospective review within 30 days. The request may be denied and penalties may apply.	
5. Oops! I didn't request authorization ***before rendering the service.*** ***I have already submitted a claim.***	Follow instructions on your remit for post-service, post-claim retrospective review. The request may be denied and penalties may apply.	
6. I disagree with the final authorization denial decision.	Submit appeal with supporting records to AZ Blue.* eviCore consultation can't be used to overturn the denial.	

** Follow the instructions in your eviCore notice about submitting additional information or requesting clinical consultations.*

How to request an eviCore peer-to-peer consultation

Providers, nurse practitioners, and physician assistants may request a clinical consultation by:

- Visiting the eviCore website at evicore.com/provider/request-a-clinical-consultation.
- Using the self-service "P2P" consultation option in eviCore's online Authorization Lookup tool. This eliminates the need to receive a scheduling callback.



Prior Authorization Requests – Quick Guide

AZ Blue (use these request options for most plans – see "Exceptions" rows below)	
AZ Blue prior authorization requests (Unscheduled admissions require notification within 48 hours)	**Online requests/status – Arizona standardized forms** Use the online request tool at "azblue.com/providers > Practice Management > Prior Authorization > AZ Blue Plans-Request AZ Standard Online." **Fax requests – Arizona standard forms** Use the fillable PDF fax forms available at Practice Management > Prior Authorization > AZ Blue Plans-Request AZ Standard Fax. **24/7 Assistance for urgent issues and transfers to post-acute care** Email us at UtilizationMgmt@azblue.com or call the numbers below for timely assistance with imminent treatment needs and transfers from acute to post-acute care facilities. Most AZ Blue plans: **602-864-4320 or 1-800-232-2345** State of Arizona employer group plans (prefixes SYD and S3Z): **1-866-287-1980** *Note: Some large groups have customized extended hours (check the member ID card for specific prior authorization and contact information)* **Gold Card Hotline: 602-864-4811**
eviCore prior authorization requests (Most AZ Blue commercial plans and all AZ Blue-administered Medicare Advantage plans)	**Online requests/status – eviCore** Access the tool by logging in to eviCore.com/provider. *Note: Although the eviCore tool is different from the AZ standardized forms,* ***AZ Blue will accept prior auth requests submitted through eviCore's online tool as valid.*** **Provider resources** Find code lists, clinical guidelines, and more on our eviCore resource page.

Exceptions:
1. **ACA StandardHealth with Health Choice plan** (prefix IAZ) Access resources via https://standardhealthhc.com/providers/pa-guidelines or call 1-800-322-8670.
2. **BlueCard® (out-of-area) plans** (members from other BCBS Plans) Use the pre-service router tool on the AZ Blue provider portal at "Practice Management > Prior Authorization > BlueCard (Out-of-Area) Members" or call the prior authorization phone number on the back of the member's ID card.
3. **CHS group plans** (large, self-funded employer groups that use a third-party administrator) Call the prior authorization phone number on back of the member's ID card.
4. **AZ Blue and TPA co-administered plans** (prefixes K8Y, K8Z, NBT, and PTP) Call the prior authorization phone number on the back of the member's ID card.
5. **FEP plans** (prefix R) Call **602-864-4102** or **1-800-345-7562** (includes evenings, weekends, and holidays for urgent issues).
6. **Medicare Advantage (MA) plans** (prefixes M2K and M3P) – Unscheduled admissions require notification within 24 hours Use the AZ Blue MA prior authorization fax form, available on our Prior Authorizations and Medical Policies page. For eviCore requests, use the online tool at eviCore.com/provider. For urgent issues after hours, call **1-888-905-1172.** For HMO members attributed to OptumCare Arizona (as indicated on the back of the ID card), use the resources at https://providers.optumcaremw.com.
7. **Medicare Supplement plans** (prefix XBS) Medicare Supplement plans align with CMS for coverage and medical necessity determinations. If a member's plan covers benefits for foreign travel emergency services, AZ Blue will determine medical necessity.

eviCore is a separate, independent company, contracted with AZ Blue to provide prior authorization services to AZ Blue providers and members.

Inpatient Notification and Prior Authorization Requirements – Quick Guide

NON-EMERGENCY ADMISSIONS		
Type of Benefit Plan	**Prior Authorization**	**Post-Admission Notification**
AZ Blue Commercial Group and Individual/Family Plans	Required only for admissions related to codes on the AZ Blue Standard prior authorization requirements list	Required within 48 hours: • Fax the face sheet to 1-844-263-2272 • Call 602-864-4320 or 1-800-232-2345
Certain Self-Funded Group Plans (prefixes PXO, SWB, SNK, SYD, S3Z, TYW)	Required for all non-emergency admissions except maternity admissions	
Federal Employee Program® (FEP®) Plans (prefix R)	Precertification or prior approval required for all non-emergency admissions except maternity admissions for a routine delivery (stays longer than 48 hours after vaginal delivery or 96 hours after cesarean require precertification of the additional days)	Required within 48 hours: Call 602-864-4102 or 1-800-345-7562
Medicare Advantage Plans (administered by AZ Blue)	Required only for admissions related to codes on the AZ Blue Medicare Advantage prior authorization requirements list	Required within 24 hours: • Fax: Use the MA Request Fax Form • Call 1-800-446-8331
BlueCard® (Out-of-Area) Plans	Call the number on the back of the ID card (UM is administered by the member's Blue Plan)	
TPA-Administered Group Plans (prefixes K8Y, K8Z, NBT, and PTP)	Call the number on the back of the ID card (UM is administered by the group's TPA)	

TRANSFERS TO DIFFERENT LEVELS OF CARE		
Type of Transfer	**Prior Authorization**	**Post-Admission Notification**
Observation → Inpatient	N/A	Required (see above for time frame and notification options by type of plan)
Acute Care → Post-Acute Care	Required	
Acute Care Facility → Another Acute Care Facility (for the same or lower level of care)	Required	
Different Levels of Care (within the same facility)	N/A	N/A